Sociodemographic and Clinical Characteristics of Patients with Dissociative Disorders in an Arabian Society

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Key Words

Hysteria • Sociodemographic profile • Dissociative disorders • Comorbid diagnosis • Personality factors • United Arab Emirates

Abstract

Objective: The aim of the study was to determine the sociodemographic and clinical characteristics of patients with dissociative disorders among psychiatric patients in the population of the United Arab Emirates. **Subjects and Methods:** Six hundred inpatients with dissociative disorders were approached during the period 1997–2003, and 468 agreed to participate in the study. These patients were recruited from Al-Ain and Tawam Teaching Hospitals and Al-Jahili Primary Health Care Centers in Al-Ain, United Arab Emirates. The study is based on a questionnaire that included sociodemographic and clinical variables. Dissociative disorders were diagnosed according to the classification set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and the International Classification of Diseases (ICD-10) of the World Health Organization. **Results:** Of the 468 patients studied, the majority (67.9%) were young, under the age of 25 years; 55% were UAE nationals, 59.4% female and 40.6%

male. Disorganized movement was significantly lower among females (34.2%) than males (44.2%, $p < 0.03$). Disapproving of the key relative behaviour was higher in females (24.1%) compared to males (13.2%); comorbid anxiety was higher in females (37.4%) vs. males (25.3%). Disturbed relationships were more common in females (40.3%) while precipitating factors, such as intolerable stressful events, were significantly higher in males (42.6%, $p < 0.01$). Furthermore, males (20.5%) had a significantly higher history of similar episodes and other psychiatric illnesses (7.5%) than females. Finally, females (41%) showed more statistically significant improvements compared to males (29.5%, $p < 0.001$). **Conclusion:** Patients under 25 years of age suffered more from dissociative disorders with no correlation to educational level as a predisposing factor. The most common symptoms were fits or unorganized movements.

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Introduction

Dissociation has been defined as a failure to integrate information and experiences in the normal way and it manifests as experiences of amnesia, depersonalization,

derealization and absorption [1]. Dissociation is a key feature in certain diagnostic groups, such as dissociative disorders [2, 3], yet although dissociation has been widely studied, there is still controversy over the classification [4–6] and epidemiology of the dissociative phenomenon [7].

Dissociative disorders were first officially classified as a separate diagnostic group in the Diagnostic and Statistical Manual of Mental Disorders III (DSM-III). Until the last decade, no standardized instrument had been designed to yield uniform diagnoses of dissociative disorders. Structured diagnostic interviews developed for other psychiatric categories did not include assessment of dissociative disorders. The development of objective screening instruments [8, 9] and structured interviews [10, 11] filled this gap and promoted empirical research leading to a change in opinions regarding the relevance of dissociative disorders in psychiatry.

The rise in the number of reported cases of dissociative disorders, particularly dissociative identity disorder in the United States [12], is interpreted by some as a result of better recognition by clinicians of these diagnoses and by others as a result of overdiagnosis (DSM-IV). Several studies have been conducted to assess the frequency of dissociative disorders in psychiatric inpatients. Rates vary between 5.0 and 58.3% for dissociative disorders in general and between 0.5 and 12.0% for dissociative identity disorder [13–18].

The concept of dissociation, a process whereby specific internal mental contents (memories, ideas, feelings, perceptions) are lost to conscious awareness and become unavailable to voluntary recall, is central to the understanding of hysteria [19]. Two major problems with this concept have detracted from its clinical value [20]. The first is the difficulty in establishing the occurrence, relevance and timing of a 'sufficient' psychological stressor. The second is the difficulty in distinguishing 'unconscious' motivation from feigning. The advent of telemetry and non-invasive imaging and improved characterization of some neurological disorders such as the dystonias have made it possible to diagnose as neurological hitherto unexplained symptoms. Yet there is strong evidence to suggest that for a core of symptoms, the disorder will remain a valid diagnosis [20].

The aim of this study was to determine the sociodemographic and clinical characteristics of patients with dissociative disorders among psychiatric patients in the United Arab Emirates (UAE).

Subjects and Methods

The data presented in this study were from patients who visited the psychiatric clinics of Al-Ain Hospital, Tawam Hospital and Al-Jahili Primary Health Care Clinic in the UAE. Al-Ain and Al-Tawam Hospitals provide comprehensive psychiatry services for all the residents in Al-Ain. They are the main tertiary care centres for psychiatric services for a large geographical area covering both urban and semi-urban regions. All researchers were trained clinicians who interviewed the subjects of the study.

Before admission, all patients were examined with specific attention to the neurological system. Appropriate laboratory investigations were requested to exclude possible physical illness. Only subjects in the age group 15–50 years were included as cases, without restriction in terms of ethnicity.

The survey included all patients who were admitted and diagnosed during the period from 1997 to 2003. Of the total patients admitted ($n = 600$), 468 gave consent to participate in the study, a response rate of 78%. Thus 22% of the inpatients with dissociative disorders were excluded from the study.

Dissociative disorders were diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) [21, 22] and the International Classification of Diseases (ICD-10) of the World Health Organization [23]. The study was based on a questionnaire that included variables on age, sex, nationality, educational level, occupation and previous psychiatric history. The validity of the Arabic version of the psychiatric instruments made available by El-Rufaie and Daradkeh [24] has been tested in earlier studies in primary health care. The information on clinical variables included symptoms, data about the previous psychiatric history, symptoms of cardiovascular, respiratory, gastrointestinal, pain, paralysis, aphonia, vision disorders, presence of comorbid conditions, and secondary gain. Treatment, intervention and final outcome were also recorded.

Most of the data were based on direct questioning of the patient, relying on the response. All clinical variables were the outcome of the clinical interviews with patients. Questions were posed to patients and a collateral history was obtained from a close relative. The list of clinical variables and information recorded on the questionnaire included the following items: premorbid personality: the patient's personal traits, interests, attitudes, religious and political beliefs before the onset of the illness; secondary gain: the patient's obtaining advantages and benefits as a result of being sick; 'acknowledged': a clear secondary gain recognized by the treatment team; 'not detected': the patient's denial or the inability of the medical team to unequivocally assess the secondary gain; 'psychogenic precipitant': the stressors on the patient's mental health that contributed to the manifestation of symptoms.

Student's *t* test was used to ascertain the significance of differences between mean values of two continuous variables and was confirmed by non-parametric Mann-Whitney test. Chi-square analysis was performed to test for differences in proportions of categorical variables between two or more groups. In 2×2 tables, the Fisher exact test (two-tailed) was used instead of chi-square when sample size was small. The level $p < 0.05$ was considered as the cutoff value for significance.

Table 1. Sociodemographic characteristics of dissociative disorders among patients by gender

Variables	Males (n = 190)	Females (n = 278)	Total
Nationality			
UAE	108 (56.5)	147 (52.9)	255 (54.5)
Arabs	62 (32.6)	104 (37.4)	166 (35.5)
Others	20 (10.5)	27 (9.7)	47 (10.0)
Age group (p < 0.001)			
≤ 25	146 (76.8)	172 (61.9)	318 (67.9)
>25	44 (23.2)	106 (38.1)	150 (32.1)
Education			
Illiterate	30 (15.8)	60 (21.6)	90 (19.2)
Primary	47 (24.7)	69 (24.8)	116 (24.8)
Intermediate	53 (27.9)	54 (19.4)	107 (22.9)
Secondary	38 (20.0)	67 (24.1)	105 (22.4)
University/college	22 (11.6)	28 (10.1)	50 (10.7)
Occupation (p < 0.001)			
Unemployed	16 (8.4)	14 (5.0)	30 (6.4)
Student	29 (15.3)	58 (20.9)	87 (18.6)
Manual	70 (36.8)	26 (9.4)	96 (20.5)
Sedentary	38 (20.0)	26 (9.4)	64 (13.7)
Housewife	0 (0.0)	131 (47.1)	131 (28.0)
Other	37 (19.5)	23 (8.3)	60 (12.8)
Previous contact with non-psychiatric service			
Faith healer	75 (39.5)	117 (42.1)	192 (41.0)
Other	2 (1)	2 (0.7)	4 (0.9)
None	113 (59.5)	159 (57.2)	272 (58.1)
Previous psychiatric history ¹			
Admitted	66 (34.7)	105 (37.5)	171 (36.5)
Outpatient visit	44 (23.2)	73 (26.3)	117 (25.0)

Percentage is given in parentheses.

¹ Multiple options including those who had a previous psychiatry history only.

Results

Of the 468 patients, more (278, 59.4%) were female than male (190, 40.6%); 55% of the subjects were Emirati nationals. The sociodemographic characteristics of patients with dissociative disorders studied by gender are given in table 1. The majority of patients were young, under the age of 25 years in both sexes ($p < 0.001$).

The frequency of common symptoms, secondary gain and comorbid conditions in patients with dissociative disorders are given in table 2. The pattern of symptoms was comparable between males and females except for fits and disorganized movements, which were significantly higher among males (44.2%) than females (34.2%, $p = 0.028$). The key relative behaviour of disapproving was more frequent in females (24.1%) compared to males (13.2%, $p < 0.001$), while secondary gain was approximately equal in both sexes; male: 82% and female: 86%. The presence

of comorbid conditions indicated higher rates of anxiety in females (37.4%) vs. males (25.3%, $p < 0.01$), and higher substance abuse in males (4.7%) vs. females (0.7%, $p < 0.01$), while other conditions were comparable.

The pattern, treatment and final outcome of psychiatric cases by gender are given in table 3. Psychological precipitating conditions such as intolerable stressful events were significantly higher in males (42.6%, $p = 0.01$) than females, while disturbed relationships were more common in females (40.3%) compared to males ($p < 0.001$). Furthermore, males (20.5%) had significantly higher history of similar episodes ($p < 0.01$) and other psychiatric illnesses (7.9%) than females ($p < 0.001$). Mental state examination also showed that male subjects had disturbed memory while female subjects had disturbed perception. Finally, female patients (41%) showed more significant improvements statistically compared to male patients (29.5%, $p < 0.001$).

Table 2. The frequency of common symptoms, key relative behaviour and comorbid conditions among patients with dissociative disorders by gender

Variables	Males (n = 190)	Females (n = 278)	Total
Symptoms ¹			
Cardiovascular symptoms	35 (18.4)	70 (25.2)	105 (22.4)
Respiratory symptoms	56 (29.5)	96 (34.5)	152 (32.5)
Gastrointestinal symptoms	10 (5.3)	22 (7.9)	32 (6.8)
Paralysis or weakness	43 (22.6)	50 (18.0)	93 (19.9)
Aphonia	47 (24.7)	67 (24.1)	114 (24.4)
Blindness/double vision	9 (4.7)	10 (3.6)	19 (4.1)
Fits/disorganized movements*	84 (44.2)	95 (34.2)	179 (38.2)
Other subjective	46 (24.2)	58 (20.9)	104 (22.2)
Key relative behaviour***			
Promoting/approving	120 (63.2)	181 (65.1)	301 (64.3)
Disapproving	25 (13.2)	67 (24.1)	92 (19.7)
Neutral	45 (23.7)	30 (10.8)	75 (16.0)
Secondary gain			
Acknowledged	156 (82.1)	239 (86.0)	395 (84.4)
Not detected	34 (17.9)	39 (14.0)	73 (15.6)
Comorbid conditions ¹			
None**	12 (6.3)	4 (1.4)	16 (3.4)
Depression	82 (43.2)	113 (40.6)	195 (41.7)
Anxiety**	48 (25.3)	104 (37.4)	152 (32.5)
PTSD	4 (2.1)	0 (0.0)	4 (0.9)
Substance abuse**	9 (4.7)	2 (0.7)	11 (2.4)
Personality disorder	29 (15.3)	44 (15.8)	73 (15.6)
Others	6 (3.2)	7 (2.5)	13 (2.8)

* p = 0.028; ** p < 0.01; *** p < 0.001.

¹ Multiple options; percentages may not add to 100%.

Discussion

To our knowledge, this is the first study to screen dissociative identity disorders among psychiatric inpatients in the UAE. Our study found that 59.4% of admissions with the diagnosis of dissociative disorders were females. The 1:1.6 female:male ratio of our study is less than the previously reported ratio of 1:15 based on a study done in Khartoum, Sudan [24]. In a conservative male-dominated society, such as the UAE, females are under many restrictions, and the best way for females to be heard may be through attracting sympathy by communicating distress through hysterical conversion. In Arab society, men have more advantages and thus do not need to adopt a sick role [25]. Furthermore, today many Emirati people feel that they are independent individuals and are more exposed to stress due to modernization and conflicting opinions regarding the exact role of females in a society which is in transition from traditional to western. In the West, there is a shift in the presentation of distress from the somatic manifestations

of hysteria to the more cognitive presentations of anxiety and depression.

Earlier studies from Saudi Arabia [26] have reported that hysterical illness/dissociative disorder was more common among subjects with low education. This is in contrast to the current study in the UAE. Our study has shown that it is evenly distributed across different educational levels, indicating that educational level is not a predisposing factor, at least in this study. In fact, only 19.2% of the subjects were illiterate. This reflects the low psychological awareness throughout the community. Lower socioeconomic status is associated with increased prevalence. Symptoms were evident in 96.4% of the subjects, which corresponds with the findings in Saudi Arabia (95%). This is higher than other reported studies such as Hafeiz [24] (76%) and Hafeiz et al. [27] (73%). Among these symptoms, fits/disorganized movements were noted to be most common (38.2%), followed by respiratory symptoms (32.5%), including shortness of breath, hyperventilation and hiccups. Hysterical blindness was among the least common symptoms (4.1%).

Table 3. Pattern of treated dissociative disorders among psychiatric patients and their final outcome by gender

Variables	Males (n = 190)	Females (n = 278)	Total
Psychogenic precipitant ¹			
Intolerable stressful events**	81 (42.6)	86 (30.9)	167 (35.7)
Conflict	43 (22.6)	54 (19.4)	97 (20.7)
Disturbed relationship***	49 (25.8)	112 (40.3)	161 (34.4)
Undiscovered	20 (10.5)	25 (9.0)	45 (9.6)
Relevant psychiatric history in family ¹			
None***	139 (73.2)	242 (87.1)	381 (81.4)
Similar episodes in close relatives**	39 (20.5)	31 (11.2)	70 (15.0)
Other psychiatric illness***	15 (7.9)	4 (1.4)	19 (4.1)
Premorbid personality ¹			
Histrionic	121 (63.7)	192 (69.1)	313 (66.9)
Antisocial	15 (7.9)	11 (4.0)	26 (5.6)
Dependent	21 (11.1)	19 (6.8)	40 (8.5)
Impulsive	22 (11.6)	45 (16.2)	67 (14.3)
Aggressive*	14 (7.4)	7 (2.5)	21 (4.5)
Mental state examination ¹			
Disturbed consciousness	77 (40.5)	124 (44.6)	201 (42.9)
Disturbed memory*	9 (4.7)	4 (1.4)	13 (2.8)
Disturbed perception*	43 (22.6)	87 (31.3)	130 (27.8)
Disturbed identity	17 (8.9)	20 (7.2)	37 (7.9)
Attention seeking personality***	95 (50.5)	196 (70.5)	291 (62.2)
Belle indifference***	37 (19.5)	15 (5.4)	52 (11.1)
Resentful denial of psychogenic precipitant*	11 (5.8)	5 (1.8)	16 (3.4)
Treatment and intervention ¹			
Psychotherapy	160 (84.2)	247 (88.8)	407 (87.0)
Placebo	54 (28.4)	73 (26.3)	127 (27.1)
Anxiolytics	20 (10.5)	30 (10.8)	50 (10.7)
Antidepressants	30 (15.8)	55 (19.8)	85 (18.2)
Outcome ¹			
No change*	7 (3.7)	2 (0.7)	9 (1.9)
Spontaneous recovery and discharge	109 (57.4)	147 (52.9)	256 (54.7)
Self-discharge*	12 (6.3)	6 (2.2)	18 (3.8)
Significant improvements**	56 (29.5)	114 (41.0)	170 (36.3)
Functional disturbance	12 (6.3)	14 (5.0)	26 (5.6)

* p < 0.05; ** p < 0.01; *** p < 0.001.
¹ Multiple options, percentages may not add to 100%.

The presenting symptoms of the subjects in the current study vary considerably from other reports. Aphonia in our study was found to be 24.4%, which is quite similar to the 21.1% found in Saudi Arabia [26], but comparatively high when compared to another study done in Eastern Saudi Arabia [28], that reported 4%. Symptoms such as fits or unorganized movements were the most common in our study sample (38.2%), compared with 21.1% in Saudi Arabia [26] and 20% in the Ljungberg [28] series from Scandinavian countries. It is quite evident that dissociative disorders not only

differ in different cultures but also within the same culture.

In the present study, intolerable stressful events preceded the onset of symptoms in 35.7% of the sample cases, which is very low compared to two studies done in Saudi Arabia that reported 62.5% [27] and 83% [26]. At the same time, 34.4% of our cases had hysterical symptoms due to a disturbed relationship and 20.7% due to conflict. It has also been found that 41.0% of the study subjects visited traditional healers over a period of 12 months before attending the psychiatric clinic. This is

similar to the results generally reported in Arab culture [29].

One limitation of this study may be whether the sample is representative of the population, because 22% of the inpatients with dissociative disorders did not participate in this study.

Conclusion

The study findings revealed that patients under 25 years of age were mostly the victims of dissociative disorders, and educational level was not a predisposing factor. Fits or unorganized movements were the most common symptom.

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